Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 28, 2017

Ms. Emma Gonsalves,
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Gonsalves:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 25, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 05/25/2017

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SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

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R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced on site investigation for three (3) anonymous complaints on 5/22, 5/23 and 5/25/17. The findings include the following:	R100	Please see attached plans of correction.	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that necessary services were provided to meet the medical, nursing and personal needs for 1 of 8 applicable residents in the sample. (Resident #4) Findings include: Per review of the medical record and interviews with staff, the RN providing care to Resident #4 on the day shift in early March failed to assess and treat the resident's condition of constipation with a bowel impaction, putting the resident at risk of further medical complications. Per RN progress note review, the resident complained to the caregiver of constipation on the morning of 3/5/17. The RN wrote that "fecal matter on side-rail by the toilet...in bathroom...5 ML of Milk of Magnesia and 100 mg. of Colace [laxatives] administered at 0800." The RN was	R126		

R126 - R208 POC's accepted 6/28/17 MBertrand RN/PMC

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called back to the room at 12:00 PM per the notes; a visitor in the room stated that the resident was vomiting and was impacted. The RN documented the resident's vital signs in the medical record but did not include any physical exam/assessment of the resident's abdomen and bowel sounds. During a telephone interview with the RN on 5/22/17 at 6:30 PM, the RN confirmed that s/he did not examine/assess the resident's abdomen or listen to bowel sounds or otherwise assess the resident prior to administering the laxatives at 0800. There was no evidence of any nursing directive to have staff provide increased monitoring of the resident after administration of the laxatives. The RN did confirm that s/he observed that the resident was impacted with stool and had vomited. The RN confirmed that they had not notified the physician of the impaction and vomiting to see if further treatment orders were indicated, putting the resident at risk of medical complications due to the fecal impaction.

It was noted on the MAR that the RN administered PRN Ativan to the resident on 3/5/17. The RN failed to completely document the reason for the PRN psychoactive medication use, the time and the effect on the resident on the back of the MAR (medication administration record). There were no other progress notes regarding the care and monitoring of the resident until 3/7/17 on the evening shift. A progress note "late entry on 3/7/17 for 3/6/17 eve, stated "Resident was given a suppository after supper on 3/6/17 resulting in a large BM later in the evening."
Per review of the "Bowel Log" used to track resident BM's, there were no dates on many of the days of the log and no consistent monitoring or oversight of bowel management program for

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R126	Continued From page 2 this population of residents who are at risk for constipation related to medical conditions and side effects of medications used. Additionally, there was no evidence of staff training in how to use the log to accurately document BM results. These concerns regarding the lack of appropriate and necessary care provision were confirmed with the DNS and the Administrator on 5/22/17/and 5/25/17.	R126		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete the State mandated assessment within 14 days of admission for 2 of 8 applicable sampled residents (Resident #2 and #4). The findings include the following: 1. Per record review Resident #2 was admitted in 2/17 with diagnoses to include, but not limited to Depression, Alzheimer's Disease and Degenerative Brain Disorder. Per interview with the Director of Nursing (DNS), on 5/23/17 at 10:40 AM, confirmation was made that the State	R134		

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R134	Continued From page 3 mandated assessment was never completed as required and the resident no longer resides at the facility. 2. Per review of the medical record for Resident #4, the following required areas of the admission assessment were left blank and incomplete: A.0.5., C.1. 1b., F.2. 3b., J.1. 1., J.2., K.3.1., K.4.1a., K.5.1., K.6.1., and 2., and N.1.1a. The incomplete admission assessment was confirmed during interview with the DNS.	R134		
R141 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (I)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and	R141		

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R141	Continued From page 4 (3) The home is able to meet the resident's needs without detracting from services to other residents; and (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully informed of their options and agree to such care in the residential care home. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to communicate to families and residents a change in the the manner in which intrusive residents are managed. Resident suites have been kept locked to prevent others from entering, including the resident who resides in that suite. The findings include the following: Per initial tour in the presence of the Director of Nurses (DNS) on 5/22/17 at 9:16 AM and through out the survey, numerous resident suites are found to be locked. Through observation, residents are heard asking staff to have their door unlocked to access their rented suite. Per interview with Resident #1's family on 5/23/17 at 8 AM, confirmation is made that the rooms were locked a couple of months ago after wandering residents would intrude and/or frighten residents who were in their own rooms. They would enter at all hours day and night. Personal items would be taken by those wandering residents who believed the items were their own. Confirmation was made during the interview that	R141		

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R141	Continued From page 5 family and or residents have not been formally notified of the change to keep resident doors locked. Per review of the admission agreement and the Resident Family Handbook there is no notation identifying the resident doors being kept locked or unlocked. Per interview with the Executive Director on 5/23/17 at 10:50 AM, confirmation is made that residents and/or families had made complaints about residents wandering in and out of the suites. Often these residents would remove personal items that were not their own and at times the intruder would void or defecate on the carpet. The past administration made the decision to lock the resident room doors to avoid any further intrusion. The Executive Director confirms that there has been no formal notification to families related to the locking of the suite doors.	R141		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by:	R145		

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R145	Continued From page 6 Based on staff interview and record review the Registered Nurse failed to develop a written plan of care to address each resident's identified needs for 2 of 8 applicable sampled residents. (Residents #2 and #4) The findings include the following: 1. Per review of medical record on 5/22/17 at 2:45 PM identifies that Resident #2 was admitted in February 2017 with diagnoses to include, but not limited to Depression, Alzheimer's Disease and Degenerative Brain Disorder. Resident #2 receives antipsychotic medications to treat symptoms of delusions, hallucinations, paranoia and confused thoughts. Behavior flow sheets identify that Resident #2 presents with delusions, paranoia and hitting. Nurses notes identify times when the resident refused medications, was intrusive to others, and often times would see others that were not present. Per review of Resident #2's care plan, there is no evidence identifying any of the targeted symptoms/behaviors, nor any direction for staff to manage those behaviors . Resident #2 was transferred to the Emergency Room in March 2017 for a psychiatric evaluation, because the resident was unmanageable. Per interview with the Director of Nurses on 5/23/17 at 1 PM confirms that a behavioral care plan cannot be located and there is no plan developed to direct staff in the management of the targeted behaviors. 2. Per record review, Resident #4 had documented behaviors related to personal hygiene management and there was no plan to address how the staff were to monitor and provide appropriate care to manage this issue.	R145		

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R145	Continued From page 7 The lack of a care plan related to personal hygiene management was confirmed during interview with the DNS on 5/23/17.	R145		
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility Registered Nurse (RN) failed to assume responsibility for staff performance for the administration of medications for 1 applicable resident (Resident #5) and destruction of a used Fentanyl (narcotic) patch in accordance with the home's policies. The findings include the following: 1. Per Medication Administration record, Resident #5 has a diagnosis of Diabetes. There is physician's order for sliding scale insulin injection to be administered at various amounts depending on the results of blood sugar tested before each meal. Per observation on 5/22/17 at 11:55 AM, the Medication Technician (Med Tech), prepares Resident #5 for an Insulin injection. S/He reviews the physician order and after completing the finger stick blood sugar that registers 300, s/he reviews the physician orders and determines that the resident is to receive 6 units of Novolog Insulin subcutaneous. S/he obtains the Insulin Pen from the medication cart,	R155		

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washes her/his hands, applies gloves, prepares the resident's skin for injection, inspects the insulin pen and injects 6 units of Novolog Insulin into the resident's abdomen. S/He documents the administration.

Per review of the Insulin Pen Injection Policy: #4 identifies Mix the Insulin by rolling the pen between the palms of your hands or tip it back and forth gently at least 20 times to mix the Insulin; #5 identifies to prime the pen which simply means making sure that the Insulin has actually filled the syringe to the tip.

Per interview with the Med Tech in the presence of the Director of Nurses (DNS) on 5/23/17 at approximately 11 AM, confirmation was made by the Med Tech, that s/he has not seen the Insulin Pen Injection Policy nor did she complete Steps #4 and #5 as the policy instructs. The DNS confirms that there has been no education conducted for the administration of injectable Insulin.

2. Per observation of the medication cart for one unit on 5/22/17 at 11:20 AM, a used Fentanyl patch was contained in a plastic bag, in the locked narcotic compartment awaiting destruction.

Per review of the Disposal of Medication the procedure, #7 identifies that all narcotic medication must be disposed of with the Charge Nurse and another employee given the authority by the Registered Nurse (RN). # 13 identifies at the time of removal from the resident when discarding a transdermal patch, cut into fours and discard in the sharps container.

Per interview with the Medication Technician and

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R155	Continued From page 9 the Director of Nurses on 5/22/17 at approximately 11:30 AM confirmation was made that the Fentanyl patch was removed from the resident earlier today and the RN was not available for destruction. Therefor, the Med Tech placed the contaminated patch back in the med cart to be discarded at a later time. Both confirm that the contaminated patch should of been discarded.	R155		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility Registered Nurse (RN) failed to obtain physician orders for the administration of prescription medications for 1 of 8 applicable sampled residents (Resident #7). The findings include the following: Per medical record review, Resident #7 has diagnoses to include, but not limited to Depression, Agitation, Anxiety, behavioral problems and Alzheimer's Disease. Per physician order dated 12/23/16, directs staff to discontinue existing Ativan orders. New order to start Ativan 0.25 milligrams (mg.) by mouth (PO) as needed (PRN). (Ativan is a sedative medication used to treat anxiety disorders.)	R162		

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Per control drug count record dated 2/17/17 at 12 noon and 3/18/17 at 2 PM Ativan 0.5 mg was signed out for Resident #7 by the Registered Nurse (RN), when it was no longer ordered for the resident at this dose. Per control drug count record dated 3/5/17 at 12 noon, 4/1/17 at 8 AM and 4/1/17 at 2:20 PM, Ativan 1 mg. tablet signed out for Resident #7 by the RN, when it was no longer ordered for the resident at this dose. Per review of the Medication Administration Record (MAR) and the Nurses progress notes, there is no identification that the medication was administered to Resident #7 by the RN. The MAR dated March 2017 identifies a hand written entry for Ativan 1 mg po every 6 hours po for anxiety as needed, which was administered as given on 3/5/17 with no documented results.

Per interview with the Director of Nurses on 5/22/17 at 2 PM confirmation was made that when discovered that the Ativan had been administered without a physician's order, an interview was conducted with the RN on the week of 5/15/17. The RN confirmed that s/he was unaware of the errors.

Per telephone interview with the RN on 5/22/17 at approximately 6:50 PM, confirmation was made that s/he was unaware of the error until notification by the DNS on the week of 5/15/17. H/She does confirm that the physician orders were never checked before the administration of the medications. Surveyor communicates that there is no progress notes or documentation on the MAR supporting the administration or the results of the administration of the Ativan. The RN could not confirm that there was no documentation related to the reasons s/he administered the medication or the results

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R162	Continued From page 11 obtained from the administration. Per facility policy titled Medication Administration, #2 identifies that medications are administered in accordance with written orders of the attending physician. Per facility policy titled Medication administration documentation, #1 identifies the individual who administers the medication records the administration on the resident's MAR at the time of administration. Per facility policy titled Narcotic Administration #4 identifies all licensed nurses are responsible for signing the Resident MAR.	R162		
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's	R168		

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condition regularly and is available when changes in condition or medication might occur.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility Registered Nurse (RN) failed to ensure that staff designated to administer injectable insulin receive additional training. The findings include the following:

1. Per observation on 5/22/17 at 11:55 AM, the Medication Technician (Med Tech) prepares Resident #5 for an Insulin injection. Per interview with the Med Tech during the preparation time, confirmation is made that s/he completed the Med Tech program at the facility over one month ago. The Med Tech confirms that s/he has not had any additional training for insulin administration, but was trained in her previous employment.

Per medication administration policy #13 (b.) identifies that designated staff have received additional training in the administration of insulin, including return demonstration and the Registered Nurse (RN) has deemed them competent. #14 identifies when a resident is receiving sliding scale Insulin, the unlicensed staff member will notify the Charge Nurse of the glucose reading and the nurse will verify the correct sliding scale does prior to the administration. The Charge Nurse will then co-sign in the Medication Administration Record to verify correct sliding scale dose was given.

Per observation by the RN Surveyor on 5/22/17 at 12 PM during the blood glucose testing and the administration of the Insulin, the Med Tech never contacted the Charge Nurse to review the

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glucose reading and never verified the correct dose of Insulin to be administered. Per interview with the Director of Nurses on 5/22/17 at approximately 12:30 PM, s/he confirms that there is no formal training for designated staff to administer Insulin by injection.

2. Per medication cart review on 5/22/17 at 11:30 AM in the presence of the Med Tech, two (2) Insulin Pens partially used were located in the locked cart with no resident's name identifying who the Insulin was prescribed for. One (1) of the Insulin pens was not dated as to when the Insulin was taken out of refrigeration and put in use. The second pen was dated 4/4/17.

Per review of Medication Storage Policy identifies that all medications used will be labeled in accordance with accepted professional standards of practice. Medications will only be used for the resident identified on the pharmacy label.

Per manufacturer's recommendations for storage of Novolog Insulin, once opened and stored at room temperature the insulin expires after 28 days. The Insulin pen that was dated (4/4/17), identifies that the resident received the outdated Insulin for 19 days. This was confirmed by the Med Tech during the inspection.

Per interview with the Director of Nurses confirmation was made on 5/22/17 at approximately 11:30 AM that the Insulin pens do not identify the resident's name and that there is no date on one of the pens identifying when the medication was taken out of refrigeration and began use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R172	Continued From page 14	R172		
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES	R172		

5.10 Medication Management

5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to ensure that all medications used in the facility are labeled with acceptable professional standards of practice and all medications shall be used only for the resident identified on the pharmacy label. For 2 Insulin pens located in one of the two medication carts, there was no identification as to whom the Insulin was prescribed for. The findings include the following:

Per medication cart review on 5/22/17 at 11:30 AM in the presence of the Medication Technician (Med Tech), two (2) Insulin Pens, partially used, were located in the locked cart with no resident's name identifying who the Insulin was prescribed for. Per review of Medication Storage Policy identifies that all medications used will be labeled in accordance with accepted professional standards of practice. Medications will only be used for the resident identified on the pharmacy label. Per interview with the Director of Nurses confirmation was made on 5/22/17 at approximately 11:30 AM that the Insulin pens do not identify the resident's name.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R206	Continued From page 15	R206		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to report a resident's allegation of abuse by a staff member to Adult Protective Services as required by 33 V.S.A. 6903, within 48 hours of learning of the reported incident. (Resident #9). findings include: Per interview on 5/25/17, the Administrator confirmed that they had discovered a file that included Resident #9's allegation that "someone hit me in my side today and my side hurts too bad to move". The resident stated to another staff member "got hit...by the girl...she had on your shirt:". (Note: The staff wear company shirts as part of a uniform.) Copies of statements were found in the file but there was no evidence it was ever reported to APS as required by Vermont Statute.	R206		
R208 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation	R208		

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R208	Continued From page 16	R208		

5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors

This REQUIREMENT is not met as evidenced by:
Based on staff interview and medical record review the facility failed to report to the licensing agency resident to resident incidents for 4 of 8 applicable residents in the sample. (Resident #1, #2, #6 and #8), who have a documented pattern of abusive behavior. The facility also failed to follow it's Abuse Protocol Procedure related to requirements for documentation of all resident to resident incidents, (including minor ones), and notification of family or legal representative. (Residents #1, #4, #6 and #8). Findings include:

1. Per medical record review for Resident #1, Nurses progress notes dated 12/18/16 identify that the resident had a witnessed altercation at around 2030 (8:30 PM) with another resident described as "pulling each other's hair, pinching and holding each other". On 1/27/17, Resident #1 had a physical altercation with another resident as s/he entered another resident's room. Resident #1 punched another resident in the back. On 3/24/17, Resident #1 went up to another resident in the hallway and hit the other resident in the face twice. On 4/23/17 the care giver found Resident #1 with her/his hands around another residents's right wrists.

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R208	Continued From page 17	R208		

2. Per medical record review for Resident #2, progress notes identify on 3/4/17 the resident was "combative to staff and employees". Follows other residents around and they complain about Resident #2's behavior and voice they feel "unsafe". On 3/19/17 Resident #2 is extremely combative, hitting and pushing a care provider second day in a row. Residents continue to feel scared, threatened and agitated about Resident #2. On 3/22/17 Resident #2 was very aggressive with staff and residents, hitting and pushing one of the directors. Transferred to Emergency Room for psychiatric evaluation.

Per review of policy titled Allegations of Abuse, identifies: #4 Incidents involving resident to resident abuse must be reported to the licensing agency if a resident alleges abuse or there is a pattern of abusive behavior. #5 identifies that the Executive Director/designee will immediately investigate the allegations.

There is no evidence at Licensing and Protection that any of the above incidents have been reported as required.

Per interview with the Executive Director on 5/23/17 at approximately 2:30 PM confirms that there are no internal files, incident reports or reports made to Licensing and Protection for Residents #1 and Resident #2.

3. Per record review, Resident #4 (female) was found in Resident #8's (male) bathroom during January, 2017 and staff failed to follow procedures for mandated reporting to the Licensing Agency and documentation of notification of the legal representative/family. Both residents involved in the incident have

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R208	Continued From page 18	R208		

dementia and were found partially clothed, with pants 'down around their ankles'. Although there was no evidence of physical injury, staff could not assure whether inappropriate unwanted sexual advances had occurred. Staff failed to report the potential sexual abuse/exploitation to the Licensing Agency and failed to develop a plan for each resident to deal with the observed behavior. Additionally, there was no evidence in the medical record nor on the incident report that any family members/legal representatives were made aware of the resident to resident event. The event was confirmed during interview with the Administrator on 5/25/27.

4. Per observation during the initial tour of the home on 5/22/17 at 9:30 AM, the surveyor and other staff present in the dining room witnessed an interaction between Resident #1 and Resident #6 and staff failed to follow it's procedure for documentation of resident to resident incidents. A caregiver present told the surveyor s/he heard a slap sound and then turned and saw Resident #6 stumble back saying "You hit me!" to Resident #1. The surveyor also heard "You hit me". The Med Tech present also saw Resident #1 push Resident #6. Per record reviews, there was no incident report completed after the observed resident incident where Resident #6 alleged abuse. As of 5/25/27, there was no report made to the Licensing Agency related to this reportable incident.

Spring Village at Essex
Specializing in Memory Care

A WoodBine Senior Living Community

June 26, 2017

Ms. Pamela M. Cota, RN
Licensing Chief
Vermont Agency of Human Services
Department of Disabilities, Agency and Independent Living
Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Cota:

In response to the letter received dated June 13, 2017 regarding the Complaint Investigation and Re-licensing survey that was completed by the Division of Licensing and Protection on May 25, 2017, I respectfully submit our Plan of Correction for the items referenced:

R126 5.5a Resident Care and Home Services (First section):
We recognize and acknowledge recorded observation on the findings under R126 for Resident Care and Home Services, Section 5.5 (General Care) that the proper procedure was not put in place for this nursing service regarding the assessment and treatment of bowel impaction.

Plan of Corrective Action
Our correction plan of action is to ensure that all Nursing staff is to adhere to our Policy and Procedures under the Laxative Use, Constipation and Bowel Incontinence:

1. Residents will be assisted to sit on the commode or toilet on a regular basis as determined by the Nurse or Physician. Residents who need assistance to toilet will be brought to the toilet every two hours. Residents with a history of incontinence will be reminded or assisted to the toilet at least upon arising and before bed, more often if determined by nursing.
2. The Charge Nurse will look at the bowel sheets every morning.
3. Residents who have not had a bowel movement for more than two days will be evaluated for the need and use of a laxative.

802-872-1700
6 Freeman Woods
Essex Junction, VT 05452
www.springvillageessex.com

4. Residents who have not had a bowel a bowel movement will be first placed on a toilet or commode to see if they are able to have a bowel movement.
5. If there is still no bowel movement, the Nurse will assess the need for further treatment and follow the standing orders signed by the provider of it not standing orders, the Nurse will call provider for further instructions
6. If Resident still does not produce a bowel movement, Nurse will notify the provider for further treatment.
7. All caregiver staff will be notified of any constipation to continue monitoring and provide routine toileting.

This plan of correction has been completed. All Bowel Logs have been updated; proper training and visual materials have been implemented. Going forward, an audit of these logs will be implemented on a weekly basis to ensure that logs are kept up to date and will be reviewed in a weekly Quality Assurance meeting.

If deemed that the process is not being adhered to, disciplinary action will occur.

R126 5.5a (Second Section)
With reference to the MAR and PRN that the RN administered, we recognize that the RN failed to complete the proper documentation, and that proper charting was not done surrounding the reasons for the PRN psychoactive medication use.

Plan of Corrective Action
Per our Medication Administration Policy, current staff will be given the policy to read and sign off confirming that they will follow the PRN policy regarding the assessment, use and documentation of such said medication. This Plan of Corrective Action will be completed by June 30, 2017.

A weekly audit will be performed by the DNS or Charge Nurse and results of the audit will be presented at our weekly Quality Assurance meeting.

If deemed that the policies are not being adhered to, this is grounds for immediate dismissal.

R134 5.7 Resident Care and Home Services
We recognize and acknowledge the findings in R134 Section 5.7 (Assessment), referencing findings 1 and 2 that State Assessments were not properly and fully completed.

Plan of Corrective Action
A full audit of all current resident charts has been completed and has been confirmed that all current Residents have a fully completed assessment. A new tracking system has been put in to place to ensure that all new Residents, and all annual assessments will be charted effective immediately. (Exhibit A)

The new tracking system will be discussed at a weekly Quality Assurance Meeting.
Completion date 7/14/17

R141 5.9a Resident Care and Home Services

We recognize that in the documented observation of R141 Section 5.9a (Level of Care and Nursing Services), the findings 1 through 5 were recorded that Residents doors were being locked to avoid other Residents intruding on another's apartment, and that this was not communicated to families.

Plan of Corrective Action

Going forward, all families will sign a request for the doors to be locked at all times should they prefer that. Such said request will be filed in the resident's charts as well as the business office.

All Residents with intrusive/wandering behaviors have a behavior plan in place to help staff assist with redirecting.

To monitor the doors and insure that Resident's preferences are being met, the Housekeeping/Maintenance Department will have a checklist and will confirm that the preferences are in place. Additional random weekly checks will occur by Executive Director. Completed checklists will reside in the Business Office.

Completion date 7/14/17

R145 5.9c (2) Resident Care and Home Services

We recognize within the documented observation of R145 Section 5.9.c (2) that the care plans for Resident #2, and Resident #4 were not accurate with their current active diagnosis.

Plan of Corrective Action

Within the findings of Resident #1 – A care plan meeting that involved family and care staff was held and a plan was put into place to reflect the current diagnosis along with identifying targeted symptoms and behaviors along with a clear behavior plan that gives direction to staff in assisting and managing these behaviors.

With regards to the findings of Resident #2: This Resident had been discharged from the hospital directly to another community before we could put a clear care plan in place.

Immediately following the exit interview, the DNS has insured that all care plans reflect the current diagnosis along with identifying targeted symptoms and behaviors of all Residents. As behaviors change, these will be documented immediately and the care plans will be updated to reflect these changes with a clear behavior plan that will give direction to staff to assist in managing these.

Behavior plans, as they are updated and created, will require the signature of the Executive Director to ensure that the behavior plan is in place. Any updates, or new plans will be discussed in a weekly Quality Assurance meeting

Completion date 7/24/17

R155 5.9c (12) Resident Care and Home Services

We recognize and acknowledge that in the recording observation in the findings under R155 Section 5.9c (12), regarding Insulin Injection Pen Policy, we recognize that the proper training and education was not provided to staff.

Plan of Corrected Action
Our local pharmacy will provide training by one of their pharmacists to ensure injections are properly administered. This will be completed by July 15, 2017.

Going forward, separate additional training will be documented for those that are under our Med-Tech Program

A step by step procedure will be written and shared with all medication administration staff once the training by the pharmacist has been completed (by July 15, 2017).

With regards to findings #2 relating to the lack of destruction of a used Fentanyl patch, we recognize the importance of the destruction of any narcotics to be done immediately. All RN's, LPN's and Med-Tech's were notified by DNS that the destruction of any and all narcotics must be done with a two-person witness, assist and sign off and must be done immediately.

Going forward, an audit will be performed by DNS on a weekly basis; results will be discussed in a weekly Quality Assurance meeting.

If staff does not adhere to the policy and procedure, disciplinary actions will be taken.

R162 5.10 Resident Care and Home Services
We recognize and acknowledge that the recorded observation on the findings under R162 Section 5.10 (Medical Management) with regards to deficiencies surrounding the administration of medication that had been changed without verifying the written Physician's order changing the dosage.

Plan of Corrected Action
A review of the Communities Policies "Medication Administration" #2: "Medications are administered in accordance with written orders of the attending physician, and a review of the Narcotics Administration by Medication (4, 5, 6 and 7) states that:

4) All delegated Medication Technicians and Licensed Nurses are responsible for signing the Resident MAR as well as controlled drug count sheet.

5) All delegated Medication Technicians and Licensed Nurses are responsible for maintaining an accurate narcotic count on their shift.

6) Licensed Nurse must evaluate effectiveness of Narcotic that was given, if the medication is PRN and document the effectiveness on the MAR and in the resident's clinical record.

7) If Narcotic was not effective, notify the Charge Nurse immediately and the Charge Nurse will call the resident's physician for further orders.

All Medication Administration Staff will be required to review the Community's policies regarding medication administration, documentation, and narcotic administration and documentation as well.

Current staff will be required to attend an in-service one on one with the DNS in which the Community Policies will be reviewed and a signed acknowledgement form will be kept on file in the Business Office. This in-service training will become part of orientation for future employees authorized to administer medication. In-service for current employees will be completed by July 7, 2017.

The DNS or delegated Charge Nurse will conduct a weekly audit of the Medication Administration Record to ensure that our policy and procedures are being adhered to. The results of the audit will be reviewed on a weekly basis in a Quality Assurance meeting.

Should the audit show that the process and procedures are not being followed, disciplinary actions will be taken.

R168 5.10 Resident Care and Home Services

We acknowledge the findings in Observation #1 and #2 regarding R168 5.10 "Medication Management" with the specific training and additional training as it relates to sliding scale insulin administration.

Observation #1 Plan of Corrective Action

Medical Administration Policy #13 - The community will immediately implement our Medication Administration Policy which states that all unlicensed delegated staff will receive additional training in the administration of insulin, including return demonstration and the Registered Nurse has deemed them competent.

Medical Administration Policy #14 – The Community will immediately implement our policy which states that "When a resident has a sliding scale for insulin the unlicensed Staff member will notify the Charge Nurse of the glucose reading and the Nurse will verify the correct sliding scale dose prior to administration and co-sign the MAR.

All unlicensed staff will receive additional training specifically for the administration of insulin with return demonstration and the Registered Nurse has deemed them competent. This additional training will be completed by July 14, 2017.

Observation #2 Plan of Corrective Action

All medications will be labeled in accordance with accepted professional standards of practice and per manufacturers recommendations.

The pharmacist will perform an in-service to DNS and nursing staff for the proper use, labeling and storage of Insulin Pen's. By way of in service, the DNS will provide additional training to all Medication Administration staff on Insulin Pen use, storage and labeling.

R172 5.10 Medication Management
We acknowledge the findings in Observation R172 - 5.10 "Medication Management" with regards to the storing of Insulin Pen's.

Observation #2 Plan of Corrective Action
All medications will be labeled in accordance with accepted professional standards of practice and per manufacturers recommendations.

The pharmacist will perform an in-service to DNS and nursing staff for the proper use, labeling and storage of Insulin Pen's. By way of in-service, the DNS will provide additional training to all Medication Administration staff on Insulin Pen use, storage and labeling.
Completion date 7/14/17

R206 – R208 5.18 and 5.18c (respectively) – Resident Care and Home Services
We recognize the findings in Observation R206 – through R208: Reporting of Abuse, Neglect or Exploitation where there was a failure to act on a resident's allegation of abuse. As we are a Memory Care Community, and the population that resides within our Community have a diagnosis of dementia, Alzheimer's and other possible cognitive impairments, it can be difficult to distinguish with our population of what is realistic and what is delusional.

Plan of Corrective Action
After a lengthy discussion with the surveyors during the exit interview conducted on May 25, 2017, regarding the above deficiencies, the Executive Director immediately imposed the Abuse Protocol Procedure with an emphasis on Sections 2, 4, 5 and 6 in which we state that:

Section 2: Spring Village at Essex will take any allegations of resident abuse by an individual (employee, another resident, family member) serious.

a) Spring Village at Essex Management and Staff are required to report suspected or report incidents of abuse, neglect or exploitation.
b) The licensing Agency is responsible for determining if the event did/did not occur. It is not the responsibility of Spring Village or the staff to make the determination as to the validity of the allegation.

Section 4: Incidents involving resident to resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse or if an injury requiring physician intervention is necessary, or if there is a pattern of abusive behavior. Spring Village at Essex will record all resident to resident incidents in their Clinical record. Families and/or legal guardian will be notified and each Resident's care plan will be updated with interventions relating to the behaviors.

Section 5: If an employee is suspected of abuse, the employee will be suspended pending outcome of the investigation.

Section 6. the Executive Director/designee will immediately investigate the allegation of abuse. To determine the timeframe and sequence of events, the staff on duty at the time, visitors and any resident witnesses will be interviewed. Written statements will be obtained from any witnesses to the alleged

incident. Any individual who is unable to provide a written statement will be questioned verbally by staff and responses will be documented. The document, if unable to be signed by the witness, will contain signatures from two (2) staff members who obtained the verbal statement.

All Spring Village employees and staff will be required to attend an in-service training to be conducted on July 18th where the Executive Director will go over the policy and procedures and the process of documenting the alleged abuse or exploitation. Staff members not able to attend mandatory meeting, will be required to meet with the Executive Director to go over said procedures.

Executive Director will emphasize the above stated process and procedure during orientation of all new employees of Spring Village at Essex.

We at Spring Village at Essex take the results of this survey very seriously. Our response and our corrective plan of action is our highest priority. An internal investigation was held after the exit interview with the Division of Licensing and Protection, and the individual(s) were immediately dismissed from service and are no longer employees of Spring Village at Essex.

We trust that this Corrective Plan of Action satisfies the regulations and requirements as outlined in the Vermont Residential Care Home Licensing Regulations.

Should you have any questions or need additional information, please feel free to contact me at (802) 872-1700.

Thank you.

Sincerely,

Emma M. Gonsalves
Executive Director

EMG/emg

EXHIBIT A

SPRING VILLAGE AT ESSEX

New Resident / Annual Assessment Charting

Resident	Move in Date	State Assessment Due within 14 days	Completed	Annual Assesment										
			Y / N / DEC Initials	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11
(Example)	9/11/2017	9/25/2017		9/25/2018	9/25/2019	9/24/2020	9/24/2021	9/24/2022	9/24/2023	9/23/2024	9/23/2025	9/23/2026	9/23/2027	9/22/2028

Y = YES N = NO DEC = Deceased